Chronic obstructive pulmonary disease assessing patient centred care nursing essa...

This project is based on the nursing care provided to a patient with Chronic Obstructive Pulmonary Disease (COPD), with specific focus on holistic assessment and identification of patient care needs. A patient profile will be provided, along with a description of COPD, including epidemiological data on incidence and prevalence and information on the causes and prognosis of the condition. Two key issues, as identified by the patient, will be analysed and a patient-centred approach to helping the patient with these issues will be demonstrated.

Patient Profile

The patient will be referred to as ‘ George’ within this project, but his real identity will remain anonymous in line with the Nursing and Midwifery Code of Conduct on patient confidentiality (NMC, 2008).

George is a 66-year old gentleman who was diagnosed with COPD approximately 1-year previously. His wife recently passed away and George is now living on his own. Adjusting to this change has been difficult for him and he has found his health deteriorating rapidly. On enquiring about George’s lifestyle, it is established that he is a heavy smoker, sometimes having over a packet of cigarettes in one day. He also mainly consumes a diet of convenience food, sharing that his wife always used to do the cooking. At 5ft 5inches and weighing 17 stones (238 pounds), George is clinically obese; his body mass index (BMI) is 39. 6. Along with the smoking, his excess weight is exacerbating the COPD and reducing his mobility. He is easily out of breath and sounds wheezy. This is his fourth self-initiated medical visit in the last month, all of which have been due to, in George’s own words, “ phlegm at the back of my mouth.”

Chronic Obstructive Pulmonary Disease (COPD)

COPD is a long-term, progressive respiratory disease affecting approximately 900, 000 people in England and Wales (NICE, 2004). It is the umbrella term to describe both chronic bronchitis and emphysema, both of which are characterised by " chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible" (WHO, 2008, p. 1). COPD is the fifth most common cause of death in the UK, taking over 30, 000 lives each year (National Statistics, 2006). By 2020, it is predicted to be the third most common cause of death worldwide (Lopez et al., 2006).

The primary cause of COPD is smoking (NICE, 2004), however, other risk factors include family history, airway hyper-responsiveness, and living in a polluted environment (Holt, 2004). The symptoms of COPD include (O'Donnell et al., 2006):

shortness of breath

chest tightness

wheezing

chronic coughing

excessive sputum

fatigue

loss of appetite and weight

Weight loss has not been a problem for George due to his unhealthy lifestyle. However, he reports all other symptoms, which are likely get worse as the disease progresses. Furthermore, if left unmanaged, COPD can lead to pulmonary hypertension and right heart failure.

Holistic Assessment

‘ Holism’ in healthcare is “ the belief that in the treatment of medical conditions, all of one’s physical, mental, emotional and social conditions – not just physical symptoms – should be taken into account” (American Holistic Nursing Association, 2010, p. 1). Holistic nursing is defined as “ all nursing that has healing the whole person as its goal” (American Holistic Nursing Association, 1998). Florence Nightingale is believed to be one of the first nurses to practice holism, focusing care on the person as a whole including consideration of their relationships and environment.

Holistic nursing is patient-centred and utilises nursing knowledge, theory, and evidence to build a therapeutic relationship with patents. Indeed, in many ways holistic nursing supports current government efforts to place the patient at the centre of their own health care, recognising the unique and subjective experience of each patient. In turn, holism also supports the increasing emphasis on self-management of long-term chronic conditions since it includes the integration of self-care and self-responsibility (Department of Health, 2008). In many ways, holistic nursing is not merely about the practice of providing nursing care, but also about attitude, philosophy and a way of ‘ being’ (Thornton, 2008).

Traditionally, before a recent call for a holistic approach to COPD assessment (NICE, 2010), the care of people with COPD adhered primarily to the medical model of health and well-being. Assessment focused on spirometry readings, which are a measure of airflow and lung volume. The severity of COPD is based on the patients' forced expiratory volume in one second (FEV1); this is the volume of air that can be exhaled in the first second of a forced expiratory manoeuvre. FEV1 readings indicate the following levels of disease severity:

FEV1 80 – 100%: Normal

FEV1 60 – 79%: Mild

FEV1 40 – 59%: Moderate

FEV1 35 – 40%: Severe

FEV1 <35%: Very Severe

George's spirometry reading was 40%, thus moderate to severe.

Recognising that the assessment should not merely focus on George's physical condition if an appropriate care plan is to be devised (Shapiro et al., 2007), Roper, Logan and Tierney's Activities of Living Model (Roper et al, 2000) was utilised (appendix 1). This is a holistic model based on the 12 activities of living (ALs) perceived to be essential components of health and well-being in humans.

The model comprises five components, all of which guided George's assessment (Box 1):

1) A patients' level of independence in each of the 12 ALs is assessed.

2) The level of nursing intervention required relates to the patient's level of dependence or independence the patient has on the nurse regarding these ALs.

3) The patient's position on a lifespan continuum from birth to death will have a bearing on the level of independence.

4) A range of factors influence ALs: biological, psychological, sociocultural, environmental and politico-economic.

5) The nursing needs to be individualised according to these ALs, level of dependence or independence in regard to ALs, age, and the influencing factors of ALs.

Box 1: Patient Assessment using the Roper, Logan and Tierney's Activities of Living Model (Roper et al, 2000)

PATIENT ASSESSMENT

Date: 03/01/2012

Patient ID: 14573

Patients Name: George Deakins Height: 5ft 5in FEV1: 40%

Age: 62-years old Weight: 17st (238lbs) Blood Pressure: 116/79

Activities of Living (D= dependent; I= independent):

– Maintaining a safe environment D I

– Communication D I

– Breathing D I

– Eating and drinking D I

– Elimination D I

– Personal grooming D I

– Controlling body temperature D I

– Mobilising D I

– Working and playing D I

– Expressing sexuality D I

– Sleeping D I

– Dying D I

Comments: George indicates areas of dependency in terms of four ALs: breathing; eating and drinking; mobilizing; and working and playing.

Influencing Factors

Biological:

George is clinically obese.

George smokes excessively (often one packet of cigarettes per day). He has been a smoker most of his life, but this has increased over the last 3-4 months.

Diagnosed with COPD approximately 1-year ago. Increased sputum and coughing over the last month.

George is 65-years of age.

Reduced mobility due to worsening COPD symptoms.

Psychological: George's wife passed away very recently (approx. 3-months ago). He is finding it difficult to adapt to ALs without her. They were married for over 30-years.

Socio-cultural: George's wife cooked his meals for him. George does not know how to cook and is currently consuming an unhealthy diet of convenience foods.

Environmental: George says that his house is very untidy without his wife; she usually did the housework. He washes dishes and cutlery as he needs them, leaving dirty plates, etc. in the sink for days at a time.

Politico-economic: No current issues relating to ALs.

The model is particularly relevant to the problems and needs expressed by George, who was currently experiencing difficulties with breathing, eating, mobilising, and actively pursuing enjoyable social activities.

Aware that an important issue within the management of George's COPD symptoms would be smoking cessation, a motivational interviewing approach was utilised within the assessment process. Motivational interviewing is a patient-centered style of counselling designed to help

people explore and resolve ambivalence about behaviour change, such as smoking cessation (Miller and Rollnick, 2009). The technique has been found to facilitate smoking cessation, smoking reduction, and reduce rates of passive smoking (Karatay et al., 2010).

Ensuring that George remained in control of identifying his own healthcare support needs, he was asked if he had any ideas as to changes he could make that might reduce his symptoms. This open-ended questioning approach underlies motivational interviewing and has been found to be effective in motivating behaviour change (Miller and Rollnick, 2009). This was the case with George, as described next.

Issue 1: Smoking Cessation

The motivational interviewing approach adopted within the holistic assessment of George highlighted an issue for which George required support. When asked about any changes he could make to reduce his symptoms, his response was, “ Smoking . . . I need to stop smoking. I have known this for a long time, but . . . it is very hard . . . there isn’t much else to do without my Jean[1]around.”

According to the stages of change model, there are five stages to lifestyle-related behaviour change (Prochaska, DiClemente, and Norcross 1992; Figure 1): 1) the pre-contemplation stage, where the individual is unaware of a problem and does not intend to change their behaviour in the near future; 2) the contemplation stage, when the individual is aware of the health risks of smoking and is considering change; 3) the preparation stage, when the individual is displaying serious resolve towards behavioural change; 4) the

action stage, which is the first few weeks and months of actively taking positive steps towards smoking cessation; and, 5) the maintenance stage, which is typically about 6-months to 5-years after initiation of the smoking cessation decision, when the individual is aware of the danger of relapse and takes action to avoid it.

Description: http://www. recoverfromheroin. co. uk/img/spiral-diagram. jpg

Figure 1: Spiral Model of Stages of Change (Prochaska, DiClemente, and Norcross 1992)

George was clearly at the contemplation stage. He was aware of the problem (i. e. smoking exacerbating his COPD symptoms) and the solution (i. e. smoking cessation), but was finding it difficult to overcome some challenging barriers (i. e. the loss of his wife, loneliness, etc.). These concerns were recognised and dealt with in a constructive manner in order to remove any perceived barriers and help George move towards the action stage (Nicol et al., 2004).

On being asked what might help him to overcome these barriers, George expressed that, “ I need to occupy my time . . . keep my hands busy.” Through discussion and collaborative decision-making, George was provided with information about his local NHS Stop Smoking programme. There is evidence that NHS intensive smoking cessation interventions are effective in both the short-term and long-term, with 13-23% of short-term quitters remaining abstinent at 52-weeks (NICE, 2007). Group interventions are reported to be particularly effective for smoking cessation (Stead and

Lancaster, 2005), and thus focus was placed on the option of group behaviour therapy via scheduled meetings.

In addition, since the literature suggests that implementation intentions (i. e. the development of a plan to engage in behaviour change) facilitate the achievement of behavioural change goals (Gollwitzer and Sheeran, 2006), George was asked to specify cues in the environment that might tempt him to smoke. These were then linked to distracting behaviours that would assist him if he encountered such cues. As found within research on the concept of implementation intentions, George appeared to find this a motivating activity (van Osch et al., 2010).

Issue 2: Activities of Daily Living

A second issue identified by George when asked what he perceived to be his greatest support need was, “ The cooking . . . I need to learn to cook or something . . . I am not too worried about my weight at the moment, but don’t want to get any bigger.”

This issue was confronted by more barriers than the smoking cessation, since the latter is currently well supported within the NHS. The possibility of ‘ meals on wheels’ was discussed, but this was not George’s preferred course of action, as indicated by his comment that, “ Meals on wheels would make me feel old. No, no . . . I’m not at that stage yet.”

After spending some time with George, looking over patient information and investigating local resources, the possibility of cooking lessons was introduced by George. He felt that it would help with the smoking cessation because it would keep him busy and give him something else to do (i. e.

experiment in the kitchen). Information on a local resource that George could utilise for such purposes was provided to him (see Resource Profile for more details).

George raised some concerns about grocery shopping when preparing to cook meals. He had only entered the supermarket once since his wife passed away, and found it “ overwhelming” and “ confusing.” On being asked if he had a computer and could do online shopping over the internet, George confirmed that he did have a computer, but found it difficult to use. He was, however, interested in the idea of ordering his groceries to be delivered to his home. Computer training was thus added to George’s care plan, offering another route of social integration and opportunities for George to occupy himself whilst trying to quit smoking. In turn, being more active and learning cooking skills would likely help with weight management.

Resource Profile

Fortunately, Norfolk offers a range of services to assist George in his efforts towards better self-management of COPD, smoking cessation, social integration, and activities of daily living. As one example, the national campaign ‘ Right Tools for the Job’, advertises that people who are serious about quitting smoking can get information and advice by ordering a free ‘ Quit Kit’ from the NHS (NHS, 2010). There is also ‘ Smokefree Norfolk,’ which provides free, confidential advice and support to people trying to quit smoking. George is also made aware that his GP surgery offers advice and might be a useful resource if he wishes to discuss the possibility of nicotine patches. Many practices also have Stop Smoking Advisors, as do many of the

pharmacies in Norfolk. Advisors can offer one-to-one advice and support at a convenient time.

Access to a Personal Health Plan, as provided by NHS Norfolk Patient Advice and Liaison, would enable George to have more control over his health and health care. It would also provide support in being able learn self-management skills. Anyone can have a plan; however, it is currently being offered to patients with COPD or heart failure.

There is a local COPD service at Queen Elizabeth Hospital, Kings Lynn (from Monday to Friday 9am – 4pm), which delivers specialist care to people in the community with a confirmed diagnosis of COPD. The service aims to avoid hospital admissions and provide general advice, among other things. The service is accessible to all patients with a Norfolk GP and is accessed via telephone or face-to-face.

In terms of learning how to cook, ‘ The Joy of Food’ provides a place for George to learn some easy recipes, whilst also being taught about nutrition and how to read food labels. Combined with access to internet training, as offered by Age Concern in Norfolk, George will have access to resources productive of independent living.

In addition to the resources available for George’s condition and the two issues he identified, George was also supplied with the Age Concern (2008) information leaflet on ‘ Bereavement: Coping with a death,’ which comprises useful information not only on dealing with the psychological implications of grief but also how to deal with practical concerns. Phone numbers for support are also provided.

Overall, all of the required resources to help George maintain his health and well-being are available within the local geographical area and no forthcoming removal of these services is evident. George even has access to wider geographical resources, such as Great Yarmouth and Waveny Community Services, who provide support in the community. If, in the future, George's condition was to worsen, which is likely due to the progressive nature of COPD, he might be able to secure the help of a district nurse who could visit him in his home. Indeed, the Community Services have published a 5-year strategy covering 2009-2014, which outlines plans to improve the services available for people with COPD (Lippa, 2010). For example, efforts will be made to reduce the number of emergency admissions arising from patients with COPD by giving some the opportunity to selfâ€ manage their condition via a telehealth pilot. This is a selfâ€ management initiative which enables people with COPD to monitor their own vital signs (i. e. blood pressure, heart rate, oxygen levels, and weight), with support and interaction being undertaken by a remote clinical team. This team provide advice on lifestyle, self-management skills, and risk assessment, as well as ensuring appropriate referrals to the GP or hospital.

Conclusion

As part of this patient-centred project, insight has been gained into the experience of living with COPD, from the patient perspective. In particular, a greater understanding of the holistic implications of the disease has been gained, providing knowledge of assessment procedures and the utilisation of such procedures in care planning. A vast array of resources have been identified to assist older people like George, who are struggling with a long-

term condition as well as age-related factors such as loss of loved ones and difficulties with activities of living. The process has been challenging, but has also demonstrated the huge beneficial impact nurses can have on a patient's health and quality of life if they take a patient-centred, holistic approach to care. The process has also contributed to continued professional development and it is anticipated that the knowledge and skills acquired during this project will enhance future patient-centred practice.

Appendix 1: The Roper, Logan and Tierney Nursing Model (Roper et al., 2000)

Level of dependence (D) or independence (I) on 12 Activities of Living (ALs):

– Maintaining a safe environment D I

– Communication D I

– Breathing D I

– Eating and drinking D I

– Elimination D I

– Personal grooming D I

– Controlling body temperature D I

– Mobilising D I

– Working and playing D I

– Expressing sexuality D I

– Sleeping D I

– Dying D I

The patient's position on a lifespan continuum from birth to death:

Birth Death

Influencing Factors:

Biological (e. g. overall health, current illness or injury, anatomy and physiology, age)

Psychological (e. g. emotion, cognition, spiritual belief, ability to understand)

Sociocultural (e. g. societal and cultural experience, expectations, values)

Environmental (e. g. damp in the home, air pollution)

Politico-economic (e. g. government, politics, economy)

Individualised care according to these ALs, level of dependence or independence in regard to ALs, position on the life continuum, and the influencing factors of ALs.